Farmington Pediatric & Adolescent Medicine, LLC

Patient Name: _____ Date of Birth: _____ Sex: M F

Race: _____ Ethnicity: _____ Language: _____

PARENT INFORMATION

Mother's Name:_____ Father's Name: _____

Mother's DOB_____ Father's DOB_____

Address: _____ Address: _____

City: _____ State: ____ Zip:_____ City: _____ State: ____ Zip: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____

With whom does the patient live? _____

Which Parent is financially responsible for medical bills not covered by insurance? _____

Emergency Contact: (Person you will allow us to contact if we cannot reach you):
Name: _____Relationship_____ Phone Number: _____

INSURANCE INFORMATION:

Primary Insurance:

Name of Ins. Co.:_____

ID#: _____

Group #: _____

Name of Card Holder: _____

Employer: _____

Relationship to Patient: _____

Secondary Insurance (write 'N/A' & initial if none)**:**

Name of Ins. Co.: _____

ID#: _____

Group ID#: _____

Name of Card Holder: _____

Employer: _____

Relationship to Patient: _____

AUTHORIZATION FOR CARE OF A MINOR

I give my permission for the physician(s) of the office of Farmington Pediatric & Adolescent Medicine, LLC and their staff to provide necessary medical care to my minor child whose name is:

_____ DOB: _____

This authorization expires on the child's 18th birthday.

Signature of Parent or Guardian: _____ Date: _____